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In the Supreme Court of the United States

DANIEL C. FANNING, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED, PETITIONER

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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QUESTION PRESENTED

Petitioner brought this class action to enjoin the federal government from seeking reimbursement pursuant to the Medicare Secondary Payer statute, 42 U.S.C. 1395y(b)(2), for Medicare payments made on behalf of Medicare beneficiaries who were members of class who participated in a class-action settlement. The question presented is whether the court of appeals correctly held that the district court lacked jurisdiction over their claims under 42 U.S.C. 405(h) because petitioner had not channeled their claims through the agency's administrative adjudication procedure.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-35a) is reported at 346 F.3d 386. The opinion of the district court (Pet. App. 36a-79a) is reported at 202 F.R.D. 154.

JURISDICTION

The judgment of the court of appeals was entered on October 10, 2003. A petition for rehearing was denied on December 16, 2003 (Pet. App. 80a-82a). The petition for a writ of certiorari was filed on March 15, 2004. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Petitioner brought this class action to enjoin the federal government from seeking reimbursement pursuant to the Medicare Secondary Payer (MSP) statute, 42 U.S.C. 1395y(b)(2), for the Medicare payments the government had made on behalf of Medicare beneficiaries who were members of a class in a class-action suit that was settled.

The MSP statute was amended in 1980 (Pub. L. No, 96-499, § 308(a), 94 Stat. 531) to curb rising Medicare costs. H.R. Rep. No. 1167, 96th Cong., 2d Sess. 352 (1980); *Zinman* v. *Shalala*, 67 F.3d 841, 843, 845 (9th Cir. 1995). The statute was designed to lower overall federal Medicare disbursements by requiring Medicare beneficiaries to exhaust all available insurance coverage before resorting to their Medicare coverage. *United States* v. *Rhode Island Insurers' Insolvency Fund*, 80 F.3d 616, 618 (1st Cir. 1996).

When an insurer under a primary plan makes a payment to a Medicare beneficiary with respect to medical care for which the Medicare program has already paid, a duplicate payment results. Absent reimbursement to Medicare, that duplicate payment results in a Medicare overpayment by operation of the MSP statute. 42 C.F.R. 405.704(b)(13); *Buckner* v. *Heckler*, 804 F.2d 258, 259 (4th Cir. 1986); H.R. Rep. No. 432, 98th Cong., 2d Sess. 1803 (1984).

A beneficiary who disagrees with the Secretary's determination that he or she received an overpayment is entitled to a hearing before the Secretary as provided in 42 U.S.C. 405(b). 42 U.S.C. 1395ff(b)(1). A beneficiary who is dissatisfied with a final decision of the Secretary after such a hearing is entitled to judicial

review of that decision, as provided in 42 U.S.C. 405(g). 42 U.S.C. 1395ff(b)(1).

The beneficiary also may ask the Secretary to waive recovery in full or in part. The Secretary may waive recovery when the beneficiary was not at fault and recovery would defeat the purposes of the Medicare Act or be against equity or good conscience. 42 U.S.C. 1395gg(c). The regulations provide that the purposes of the Medicare Act would be defeated if the Secretary's recovery would deprive a person of income required for ordinary and necessary living expenses, including medical expenses. 42 C.F.R. 405.358, 405.508(a). The Secretary's waiver determination is subject to administrative and judicial review. 42 U.S.C. 1395ff(b)(1); 42 C.F.R. 405.704(b)(14), 405.720-405.730.

The second and third sentences of Section 205(h) of Title II of the Social Security Act, 42 U.S.C. 405(h), made applicable to the Medicare Act by 42 U.S.C. 1395ii, provide:

> No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

2. This case arises out of the 1997 settlement of mass tort litigation against AcroMed Corporation, a manufacturer of orthopedic bone screws used in spinal fusion surgery. Pet. App. 6a-7a; see *Buckman Co.* v. *Plaintiffs' Legal Comm.*, 531 U.S. 341, 347 (2001) (describing proceedings). When the United States learned of the proposed settlement, it informed the settling parties that, to the extent the government had made Medicare

payments for the class members' bone screw settlement-related medical care, the Medicare Secondary Payer statute required that Medicare be reimbursed. Pet. App. 7a. The final settlement agreement required AcroMed to pay $100 million into a settlement fund for distribution to class members who qualified for payment in accordance with a procedure to be established by the court. *Ibid.* The settlement agreement did not provide for reimbursement of the government's Medicare payments.

Efforts to settle the government's claims failed when petitioner filed this class action lawsuit, seeking to enjoin the federal government from taking any action to recover Medicare payments from members of the class. The government ultimately sent letters to approximately 1800 Medicare beneficiaries in the AcroMed settlement class that notified each of the beneficiaries of Medicare's claim and that indicated the particular amount of reimbursement that was required.* The letters noted that interest would accrue if payment was not made in a timely fashion, and that the Medicare program has the right to recover unpaid amounts through offsets against other federal benefits. Pet. App. 96a.

The letters further explained that beneficiaries have the right to file an administrative appeal of the agency's determination that they are required to reimburse the Medicare program, and the letters set out the process for doing so. Pet. App. 98a. The letters also explained

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* The amount of reimbursement sought varied widely. For example, while the letter that petitioner has included in the petition appendix sought nearly $12,000, Pet. App. 94a, the government sought only $8.71 in reimbursement from Fanning himself. *Id.* at 45a.

that beneficiaries have the right to request that the Medicare program waive its recovery in whole or in part, and explained that the program may do so if the overpayment was not the beneficiary's fault and repayment would cause financial hardship or be unfair for some other reason. *Id.* at 97a.

The amended complaint (filed after the Secretary's letters were sent) alleged that, as a statutory matter, the payments made pursuant to the AcroMed settlement did not give the federal government a right to reimbursement under the MSP provisions. Pet. App. 8a. The complaint also alleged that the government's efforts to obtain reimbursement violated the class members' due process rights. *Id.* at 40a.

The government moved to dismiss the complaint for lack of subject matter jurisdiction because the class members had not presented their claims to the agency as required by 42 U.S.C. 405(g) and (h). The district court denied the motion. Pet. App. 36a-79a. The court reasoned that those provisions did not apply to petitioner's claims because the class members were not seeking to recover Medicare benefits but were instead seeking to enjoin the government from collecting funds it had already paid. *Id.* at 69a.

In the same ruling, the district court entered a preliminary injunction barring the government from taking any steps to obtain reimbursement for its Medicare payments from the class members. The court offered two statutory reasons for its conclusion that the payments from the AcroMed settlement did not trigger the federal government's right to reimbursement for its Medicare payments. Pet. App. 49a-66a. First, the court ruled that AcroMed could not be regarded as having a "self-insured plan" that was primary to Medicare under 42 U.S.C. 1395y(b)(2). Pet. App. 54a-60a. Second, the

court ruled that the government has no right to reimbursement because AcroMed could not reasonably have been expected to make "prompt" payment at the time Medicare paid for a class member's medical care under 42 U.S.C. 1395y(b)(2). Pet. App. 60a-66a. The court did not rely upon petitioner's due process claims as a separate basis for the injunction or otherwise address those claims.

3. A unanimous panel of the Third Circuit reversed, holding that the district court lacked subject matter jurisdiction over the lawsuit. Pet. App. 1a-35a. The court concluded that, under 42 U.S.C. 405(h), challenges to the Secretary's overpayment determinations must be presented administratively before they may be heard in court. Pet. App. 11a-12a.

The court observed that this Court had already rejected the distinction, drawn by the district court, between actions to recover benefits and actions to preclude the government from collecting reimbursement for benefits already paid. Pet. App. 25a-28a (describing *Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000)). The court likewise explained that, under this Court's precedents, a due process claim that is intertwined with a statutory claim to benefits must be presented to the agency, regardless of whether the agency would have discretion to consider the constitutional challenge. *Id.* at 13a-21a (describing *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), and *Heckler* v. *Ringer*, 466 U.S. 602 (1984)).

Finally, the court of appeals explained that this case is unlike *Bowen* v. *Michigan Academy Family Physicians*, 476 U.S. 667 (1986), where the plaintiff had no avenue of administrative review. The court stressed that petitioner was "plainly wrong" in contending that class members had no right to administrative review of

the agency's demand for MSP reimbursement. Pet. App. 30a, 31a. The court observed that the letters sent to class members "clearly advised them of the administrative process by which they could appeal the agency's determination or, in the alternative, seek a waiver of Medicare's claim for reimbursement," a process that was likewise set out in the Medicare Intermediary Manual. *Id.* at 31a.

ARGUMENT

The court of appeals correctly held that the district court lacked subject matter jurisdiction over this lawsuit because the class members have not presented their claims to the agency. Petitioner does not allege a conflict with the decision of another court of appeals. The petition should thus be denied.

1. As this Court has explained, related provisions of the Medicare and Social Security Acts "channel[] most, if not all, Medicare claims through [a] special review system" that requires that claims be presented administratively before judicial review may be sought. *Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 8 (2000). Under 42 U.S.C. 405(g), only final decisions of the Secretary are subject to judicial review in federal district court. Section 405(h) makes that avenue of judicial review exclusive, by providing that "[n]o action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter." 42 U.S.C. 405(h). Pursuant to 42 U.S.C. 1395ii, Section 405(h) applies to the Medicare Act to the same extent that it applies to the Social Security Act. *Illinois Council*, 529 U.S. at 8-9.

As the court of appeals observed, this Court has repeatedly rejected efforts to read Section 405(h) narrowly. Thus, in *Weinberger* v. *Salfi*, 422 U.S. 749, 760-761 (1975), the Court held that due process and equal protection challenges to a statutory condition on receipt of survivor's benefits must be channeled through the agency because the Social Security Act provided both the standing and the substantive basis for the claim to benefits. Likewise, in *Heckler* v. *Ringer*, 466 U.S. 602, 614-615 (1984), the Court held that an effort to enjoin a Medicare policy on due process grounds must be channeled through the agency. In *Illinois Council*, the Court confirmed that it would not "accept a distinction that limits the scope of [Section] 405(h) to claims for monetary benefits." 529 U.S. at 14.

Under those decisions, the class members were required to channel their challenges to the agency's overpayment determinations through the agency. The Medicare Act provides both the standing and substantive basis for the claims, which in "essence" allege that the Medicare payments made on behalf of class members should be treated as primary, rather than secondary, to the payments made under the AcroMed settlement. As the court appeals correctly explained:

> [T]he claim asserted in the amended class action complaint is wholly dependent upon determining whether or not AcroMed is a "self-insured plan" and, therefore, a "primary plan" under the MSP. It is thus apparent that both the standing and the substantive basis for the claim asserted in the amended class action complaint are rooted in, and derived from, the Medicare Act.

Pet. App. 29a-30a (footnote omitted).

2. The petition does not discuss the statutory claims that provided the basis for the district court's injunction, but focuses exclusively on the due process claims that the district court did not address. The petition urges that, to the extent the class has presented procedural due process challenges to the letters sent to class members, the class could not have obtained adequate relief from the agency, and that therefore class members should have been entitled to bring their constitutional challenges in a suit based on 28 U.S.C. 1331, outside the exclusive review provisions of 42 U.S.C. 405. Pet. 12. That contention, however, is foreclosed by this Court's decision in *Weinberger* v. *Salfi*, 422 U.S. at 764, which held that determinations by the Secretary which are allegedly unconstitutional and "which are beyond the power of the Secretary to affect" are nonetheless decisions that must be channeled through the agency under Section 405(h). And in *Mathews* v. *Eldridge*, 424 U.S. 319, 326-332 (1976), the Court made clear that 42 U.S.C. 405(g) provides the only avenue for judicial review even where, as here, the claimant raises a procedural due process challenge to the administrative procedures used by the agency in denying benefits. See also *Califano* v. *Yamasaki*, 442 U.S. 682 (1979) (suit properly brought under 42 U.S.C. 405(g) to challenge procedures for determining whether an overpayment of Social Security benefits had occurred and whether a waiver of recoupment should be granted.)

Moreover, this Court should not consider petitioner's contention because it was not passed upon below. Before the court of appeals, petitioner below did not distinguish between the statutory and constitutional claims. Instead, petitioner urged that the class members had no administrative appeal rights for *any* of

their claims because the government's administrative determinations were themselves not authorized by the MSP statute. See, *e.g.*, C.A. Br. 37 ("Congress only authorized the Government to recover payments it made as an alleged statutory secondary payer by bringing a civil action in court and not through administrative adjudication."). The court of appeals properly rejected that contention in light of the established administrative procedures used in processing appeals of MSP overpayment and waiver determinations. Pet. App. 31a. That ruling also is consistent with the decisions of the other courts of appeals addressing the issue. *Cochran* v. *Health Care Fin. Admin.*, 291 F.3d 775 (11th Cir. 2002) (dismissing suit challenging MSP liability because beneficiary had failed to exhaust her administrative remedies); *Buckner* v. *Heckler*, 804 F.2d 258 (4th Cir. 1986) (same).

In any event, petitioner's due process claims rest on a faulty premise. The petition purports to argue that the government has deprived class members of property without providing a pre-deprivation opportunity to challenge the agency's overpayment determinations. Pet. 9-13. The Secretary's letters sent out to the class, however, clearly explained that a beneficiary may challenge the agency's determination administratively and/or seek a waiver. There also is no evidence in the record suggesting that the government has attempted or would attempt to recover reimbursement (through offset or otherwise) while a class member's administrative appeal or waiver request is pending. Moreover, the Secretary's administrative procedures would provide petitioner and those class members similarly situated with precisely the type of avenue petitioner says is necessary to determine whether class members received an overpayment under Medicare, for which the

beneficiary is liable to the Secretary under the MSP. See, *e.g.*, Pet. 10-11. The petition thus presents no issue warranting this Court's review.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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